blood pressure and blood cholesterol concentrations at entry.

Even if the principal finding is accepted as valid, we question the explanation offered for it. We believe that a higher cumulative exposure to tobacco (a known predictor of mortality, particularly from lung cancer[2]) among switchers is more likely to account for the observed differences in mortality than are minor variations in inhaling. This is for two reasons. Firstly, switchers are by definition former cigarette smokers, who, as the paper shows, have a higher consumption of tobacco than cigar and pipe smokers. Secondly, switchers are likely to have had a longer duration of exposure to tobacco since they had all given up smoking cigarettes at least 20 years before the health examination, and there were no reported criteria for duration of smoking among non-switchers.

The study confirms previous findings that mortality is higher among cigar and pipe smokers than non-smokers.[3] Therefore, we believe that healthcare workers should advise cigar and pipe smokers to give up completely and, if the findings from this study are confirmed, could justifiably concentrate their efforts on cigar and pipe smokers who formerly smoked cigarettes as a particularly high risk group.

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1 Wald NJ, Watt HC. Prospective study of effect of switching from cigarettes to pipes or cigars on mortality from three smoking related diseases. *BMJ* 1997;314:1860-3. (28 June.)
2 Kahn HA. *The Dorn study of smoking mortality among US veterans.* Bethesda, MD: National Cancer Institute, 1966: 1-125. (National Cancer Institute monograph 19.)
3 Doll R, Peto R. Mortality in relation to smoking: 20 years' observations on male British doctors. *BMJ* 1976;ii: 1525-36.

American study supported conclusions

EDITOR—Wald and Watt presented results of a prospective study indicating that cigarette smokers decrease their chance of death from ischaemic heart disease, lung cancer, and chronic obstructive lung disease by switching to cigars or pipes.[1] The study was limited by small numbers of deaths, particularly from lung cancer, on which changing smoking habits would be expected to have the greatest impact; an inability to evaluate cigar and pipe smoking separately; and the use of disease mortality rather than incidence. The findings prompted us to re-examine data from a large case-control study of lung cancer carried out at seven locations in Europe.

There were 6919 male incident cases of lung cancer and 13 458 controls,[2 3] including 573 cases and 1036 controls who smoked cigarettes and cigars or pipes and 15 cases and 56 controls who switched from cigarettes to cigars or pipes. Previous analyses concluded that cigarette smokers who switched from non-filter to filter cigarettes or reduced the number of cigarettes smoked per day lowered their risk of lung cancer.[4 5]

Table 1 Number of cases and controls in study by status as current or former smoker,* and relative risk of lung cancer†; data are on men only

Smoking status	Current smoker		Former smoker		Relative risk (95% CI)	
	Cases	Controls	Cases	Controls	Current smoker	Former smoker
Cigarettes only	5131	6681	911	2662	11.2 (9.6 to 13.1)	4.52 (3.8 to 5.3)‡
Cigars only	28	98	9	46	3.69 (2.4 to 5.8)	2.40 (1.2 to 5.0)
Pipe only	35	165	4	32	2.91 (2.0 to 4.3)	1.54 (0.6 to 4.5)
Cigarettes and cigars§	138	230	32	97	7.92 (6.1 to 9.6)	4.12 (2.7 to 6.3)‡
Switch from cigarettes to cigars¶	8	29	1	5	3.95 (1.8 to 8.8)	2.42 (0.3 to 20.9)
Cigarettes and pipes§	262	367	42	164	9.88 (7.9 to 12.3)	3.37 (2.3 to 4.9)‡
Switch from cigarettes to pipes**	5	15	1	7	4.57 (1.6 to 12.8)	2.00 (0.2 to 16.4)
Cigars and pipes	17	48	6	17	4.46 (2.5 to 7.9)	3.93 (1.5 to 10.1)
Cigarettes, cigars, and pipes	76	111	23	67	9.12 (6.6 to 12.7)	4.42 (2.7 to 7.3)‡

*Current smokers included those who stopped smoking within five years of date of occurrence of cancer (cases) or interview (controls).
†Reference category was lifelong non-smokers (190 cases and 2617 controls). Relative risks were adjusted for age and study location.
‡Relative risks significantly different for current and former smokers, P<0.01.
§Subjects who consumed cigarettes and cigars or pipes concurrently.
¶Mean of 18 years (median 15 years) from cessation of cigarette use to age at diagnosis (case) or interview (control).
**Mean of 24 years (median 21 years) from cessation of cigarette use to age at diagnosis (case) or interview (control).

Table 2 Number of cases and controls for cigarette and cigar smokers or cigarette and pipe smokers by status as current or former smoker* and relative risk of lung cancer†

	Current cigarette smoker		Former cigarette smoker		Relative risk (95% CI)	
	Cases	Controls	Cases	Controls	Current cigarette smoker	Former cigarette smoker
Current cigar smoker	93	138	21	58	10.9 (7.8 to 15.4)	5.01 (2.9 to 8.7)
Former cigar smoker	24	34	32	97	12.4 (7.0 to 22.0)	4.59 (2.9 to 7.2)
Current pipe smoker	145	195	28	52	11.6 (8.7 to 15.4)	7.63 (4.6 to 12.6)
Former pipe smoker	88	120	42	164	11.4 (8.2 to 15.9)	3.52 (2.4 to 5.2)

*Current smokers included subjects who stopped smoking within five years of date of diagnosis (cases) or interview (controls). Table excludes smokers who switched from cigarettes to cigars or pipes; cigar and pipe smokers; and cigarettes, cigars, and pipe smokers.
†Reference category was lifelong non-smokers (190 cases and 2617 controls). Relative risks were adjusted for age and study location.

Relative risks of lung cancer were lower for former than current smokers (table 1). In addition, relative risks for cigarette and cigar or pipe smokers were lower than those for cigarette-only smokers but higher than those for cigar-only, pipe-only, and cigar and pipe smokers. Those who switched from cigarettes to cigars or pipes had risks similar to those of cigar-only and pipe-only smokers.

For cigarette and cigar or pipe smokers, relative risks for former smokers declined only if subjects stopped smoking cigarettes (table 2). The relative risk was 10.9 for current cigarette and cigar smokers, increased to 12.4 for former cigar smokers who continued to smoke cigarettes, and fell to 5.0 for former cigarette smokers who continued to smoke cigars. The relative risk for subjects who stopped smoking cigarettes and cigars was 4.6. A similar pattern occurred for cigarette and pipe smokers. Relative risks were 11.6 for current cigarette and pipe smokers, 11.4 for former pipe smokers who continued smoking cigarettes, 7.6 for former cigarette smokers who continued smoking pipes, and 3.5 for subjects who stopped smoking cigarettes and pipes.

Our analysis showed that cigarette smokers who switch to cigars or pipes reduce their risk of lung cancer, thus supporting the conclusion of Wald and Watt. We also found that mixed smokers who stop smoking cigarettes but continue smoking cigars or pipes also lower their risk of lung cancer, although they continue to incur a risk five times higher than that of non-smokers.

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1 Wald NJ, Watt HC. Prospective study of effect of switching from cigarettes to pipes or cigars on mortality from three smoking related diseases. *BMJ* 1997;314:1860-3. (28 June.)
2 Lubin JH, Blot WJ, Berrino F, Flamant R, Gillis CR, Kunze M, et al. Patterns of lung cancer risk among filter and non-filter smokers. *Int J Cancer* 1984;33:569-76.
3 Lubin JH, Richter BS, Blot WJ. Lung cancer risk with cigar and pipe use. *JNCI* 1984;73:377-82.
4 Lubin JH, Blot WJ, Berrino F, Flamant R, Gillis CR, Kunze M, et al. Modifying risk of developing lung cancer by changing habits of cigarette smoking. *BMJ* 1984; 288:1953-6.
5 Lubin JH. Modifying risk of developing lung cancer by changing habits of cigarette smoking. *BMJ* 1984;289:921.

Authors' reply

EDITOR—The risk of lung cancer among current cigarette smokers compared with lifelong non-smokers in our paper (a 16-fold increase) is virtually the same as that found in the prospective study of British

physicians (a 15-fold increase).[1] This confirms that our estimate of risk is reasonably accurate. The risk of death from lung cancer in lifelong non-smokers was 7.8 per 100 000 per year (95% confidence interval 3.7 to 16.5) in our study, which was of men aged 35-64 at entry who were followed up for an average of 14 years and 4 months.

Jarvis expresses concern that the men who switched from smoking cigarettes to smoking pipes and cigars (switchers) may have had lower former cigarette consumption than those who continued to smoke cigarettes, in which case there would not necessarily be a reduction in risk because it would be lower anyway. This is possible, although our data suggest that, if so, it had only a small effect. In men aged 15-24 the mean cigarette consumption in switchers and continuing cigarette smokers was the same, and in men aged 25-34 it was on average three cigarettes a day lower among switchers. This indicates that most of the difference in risk between switchers and continuing cigarette smokers is likely to be a reduction in risk as a result of switching.

We agree with Edwards and Jakubovic that obtaining repeated measures of smoking habit would improve the precision of smoking data, but it is remarkable that a single assessment of smoking was so predictive of mortality many years later. If there were any error, it is more likely that it would have masked effects, not "created" them. We believe that confounding is a material issue only with respect to heart disease, and we adjusted for blood pressure and serum cholesterol concentration, which are two factors that are strongly related to ischaemic heart disease. It is unlikely that other factors would introduce significant confounding. We acknowledge that the amount of tobacco smoked per day may be more important than the extent of inhaling in determining risk of smoking related death, but there is evidence that both are involved.

Finally, we were pleased to see the corroborative results of Lubin and Fraumeni.

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1 Doll R, Peto R, Wheatley K, Gray R, Sutherland I. Mortality in relation to smoking: 40 years' observations on male British doctors. *BMJ* 1994;309:901-11.

Fact that no SHO post was given five years' approval is worrying

EDITOR—In his letter about the approval of senior house office posts, Lloyd (the secretary of the Royal College of Physicians) explains that limited approval is given to posts that are found to be inadequate.[1] In attempting to defend the college he highlights a fundamental facet of the problem. He states that "each quarter the director of training submits to the council a report on posts visited. If everything is in order a post is given approval for five years." He then points out that none of the last 388 posts inspected was found acceptable enough to be given approval for five years. This suggests either that the overall standard of training is so poor that no hospital makes the grade or that the college is being unrealistic in its options. Neither of these, I would have thought, is something to be proud of.

Lloyd states that withdrawal of approval for training has serious repercussions for the provision of services. Thus, obviously, any trust that wishes to avoid having a senior house officer post withdrawn should merely ensure that its juniors are so overworked that the college could not possibly think of removing approval.

I would like to think that the director of training is more worried about the possible impact on the individual trainee. What should be available is a system for picking up those trainees who have been ill served and perhaps finding them a remedial placement.

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1 Lloyd DB. Approval of SHO posts is rarely withdrawn but is often given for limited time. *BMJ* 1997;315:1163. (1 November.)

BUPA and the tobacco industry

Chairperson of BUPA in Republic of Ireland is also chairperson of tobacco producer

EDITOR—I was delighted to see that Wald and Watt, from the BUPA Epidemiological Research Group, were able to state conclusively that there were no conflicts of interest evident in their study on smoking related diseases.[1] In the same issue of the *BMJ* the BUPA Foundation advertised generous research awards for communication, epidemiology, health at work, and research. Could this be the same BUPA that has recently established a division in the Republic of Ireland and has had the foresight to appoint one of our most successful businesswomen, Dr Margaret Downes, as its chairperson? That she is also the chairperson of one of the biggest tobacco producers in the Republic of Ireland (Gallaher) seems to be irrelevant to BUPA. One cannot readily criticise Dr Downes for accepting the offer to chair BUPA Ireland—after all, being chairperson of BUPA must offer some degree of respectability, and the tobacco industry is in short supply of that. Furthermore, it is probably the best each-way bet one could hope for (especially if you work for the tobacco industry)—profits when the smokers are smoking and profits when the smokers are dying.

Surely someone in BUPA can see the potential conflicts of interest in this appointment. If they have difficulty in doing so, perhaps some of the recipients of their largesse in the United Kingdom would point out the hard realities to them and do us all a favour.

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1 Wald NJ, Watt HC. Prospective study of effect of switching from cigarettes to pipes or cigars on mortality from three smoking related diseases. *BMJ* 1997;314:1860-3. (28 June.)

Reply from BUPA Ireland

EDITOR—Dr Margaret Downes is a highly respected non-executive chairman of BUPA Ireland, whose skills and integrity are widely recognised. As with her many other directorships, she is not involved in the day to day operations or decision making of this company. Her primary responsibilities relate to board and corporate governance matters, for which she is eminently qualified.

It is public policy in Ireland, under the 1994 Health Insurance Act, to operate a community rated system which does not discriminate between subscribers to health insurance because of their lifestyle choices. BUPA Ireland is bound by the public policy requirements.

The fact that Dr Downes is the chair of Gallaher Ireland and of BUPA Ireland is public information, and no attempt has been made to conceal it. She was appointed by BUPA because of her expertise in financial services, health care, and business management: she was the best person for the job.

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Community based programmes can help to manage tuberculosis more effectively

EDITOR—In many low income countries the cure rates achieved by tuberculosis field programmes (for sputum smear positive cases) exceed the 85% target set by the World Health Organisation.[1] However, the decision to favour outpatient rather than hospital treatment of tuberculosis in many such countries has been influenced by several factors not mentioned in Squire and Wilkinson's editorial[2] that were only alluded to in the two accompanying papers.[3,4]

Programmes to control tuberculosis are often the responsibility of the divisions for public health, primary healthcare, or control of communicable diseases within the countries' health ministries. Hospitals, particularly at secondary or tertiary referral level (provincial, regional, and university hospitals), usually fall under another division, or even another ministry. Those working in the control programme often have neither the authority nor the status to promote national policy guidelines in these hospitals. This may result in misdiagnosis, idiosyncratic drug regimens, and inadequate documentation and reporting for patients managed by hospitals. In contrast, community centres, clinics, and dispen-

saries which are directly supervised by—often comparatively junior—programme staff can assume better control and contribute to programme activities in many ways.

The situation in private practice is even more confused. Patients may select only part of the treatment regimen because of the expense involved and may default from treatment after a few weeks, once they start to feel better. Attempts to trace such patients who drop out are rarely undertaken. Co-operation with the control programme—which can help with training, open access to sputum microscopy services, free supplies of drugs, and accompanying monitoring—is essential if there is to be a unified strategy on how to treat the disease.

The national programme incorporating "DOTS" (directly observed treatment, short course) needs to be flexible. In Indonesia, a nominated observer (usually a relative, but it could be a neighbour or influential fellow villager) is briefed carefully and entrusted to be responsible for seeing every home dose taken. This observer can be as effective as a worker based at a health centre. Many patients have their disease diagnosed and documented, receive advice and encouragement, and are started on treatment at a health centre, with their nominated observer in attendance. These patients do not have to go to the district or provincial hospital. We are beginning to see satisfactory cure and completion rates from the rural area. The cities, however, are quite another problem.

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1 World Health Organisation. *Report on the tuberculosis epidemic 1997*. Geneva: WHO, 1997.
2 Squire SB, Wilkinson D. Strengthening "DOTS" through community care for tuberculosis. *BMJ* 1997;315:1395-6. (29 November.)
3 Volmink J, Garner P. Systematic review of randomised controlled trials of strategies to promote adherence to tuberculosis treatment. *BMJ* 1997;315:1403-6. (29 November.)
4 Floyd K, Wilkinson D, Gilks C. Comparison of cost effectiveness of directly observed treatment (DOT) and conventionally delivered treatment for tuberculosis: experience from rural South Africa. *BMJ* 1997;315:1407-11. (29 November.)

Cognitive dysfunction after concussion

Authors did not to comment on the single truly significant result

EDITOR—Teasdale and Engberg examined the duration of cognitive dysfunction after concussive head injury in young men.[1] We are concerned about their interpretation of some of the data presented. The observation that cognitive function was impaired up to one week after head injury was based on examination of only eight subjects, four of whom showed impaired performance. The authors placed considerable weight on this result even though the relative risk of cognitive impairment in the subjects with head injury was not significant by conventional criteria. It was additionally perplexing, given this non-significant result, that the 95% confidence interval did not pass through unity. Perhaps most surprising of all was that the authors failed to comment on the one truly significant result in that section of the paper—that impaired cognitive performance was shown in those subjects tested more than 200 days after the head injury.

The other main finding, that the risk of concussion was greater in subjects with premorbid cognitive dysfunction, is readily understandable. It is disconcerting, however, that a similar degree of cognitive dysfunction was not apparent in subjects tested after head injury. The authors suggested that this may have been due to differences in the mean age of men tested before and after head injury (20.6 years and 18.0 years, respectively). There was indeed a greater frequency of dysfunctional scores in men injured at age ≤18 than in those injured at age ≥19. These data, however, were derived from the combined test results of men examined both before and after head injury. The authors' argument would be strengthened if a similar age difference were to be shown individually in both groups.

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1 Teasdale TW, Engberg A. Duration of cognitive dysfunction after concussion, and cognitive dysfunction as a risk factor: a population study of young men. *BMJ* 1997;315:569-72. (6 September.)

Authors' reply

EDITOR—Our finding of an increased rate of cognitive dysfunction among subjects tested within one week of sustaining concussion was unsurprising given the numerous studies pointing to the same conclusion.[1] The marginal lack of significance of the binomial test (P = 0.06) is due to a lack of statistical power when only eight subjects are studied. That the lower limit of the 95% confidence interval for the risk ratio should nevertheless lie above unity (1.23) is certainly anomalous, but such discrepancies can arise given the different calculations involved.

Interpretation of significant cognitive dysfunction over 200 days after concussion needed to be deferred until the results for those injured after being tested were examined. It then seemed that there was an increased rate of cognitive dysfunction among subjects whether they were tested before or after sustaining concussion. This pointed to cognitive dysfunction being a risk factor for concussion. That the risk factor had manifested itself more strongly in those subjects who were injured after being tested could have been due to their being relatively older at injury than those subjects injured before being tested (four fifths of whom were injured more than six months before testing). We found a lower rate of cognitive dysfunction among those injured at age ≤18 than those injured at age ≥19. Strachan et al suggest that this argument would be strengthened if both groups were subdivided according to whether they sustained concussion before or after being tested. The table shows the relevant data.

The table provides only partial support for our argument in that the age effect appears only among those injured after testing. There is, however, substantial confounding between age at injury and whether testing took place before or after the injury. Furthermore, dichotomising age involves a reduction of information. In a stepwise logistic regression we found age at injury to be significantly related to the test score (dysfunctional/normal) (P = 0.017), and thereafter there was no significant contribution of injury before or after testing (P = 0.45). In default of alternative hypotheses, we therefore continue to believe that the poorer performance in cognitive tests of those young men who were tested before they sustained concussion may well be explained by factors related to their relatively greater age at injury.

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1 Bohnen N, Jolles J. Neurobehavioral aspects of post-concussive symptoms after mild head injury. *J Nerv Ment Dis* 1992;180:683-92.

Determining prognosis after acute myocardial infarction in the thrombolytic era

Rescue angioplasty after failed thrombolysis may put patients at risk

EDITOR—Beller brings to readers' attention the fact that routine invasive procedures after acute myocardial infarction offer no significant benefit over that offered by the routine practice of risk stratification with non-invasive methods.[1] We are concerned, however, with the blanket statement that high risk patients should have early angioplasty or rescue angioplasty after failed thrombolysis. This technique should be used with caution.

A meta-analysis by Ellis et al indicated a mortality of 10.6% after the procedure, either

Number (percentage) of men who were injured before or after test of cognitive function, by age at injury

Age at injury (years)	Injury before test			Injury after test		
	Dysfunctional	Normal	Total	Dysfunctional	Normal	Total
≤18	150 (24.8)	456 (75.2)	606	4 (9.8)	37 (90.2)	41
≥19	21 (22.3)	73 (77.7)	94	154 (32.2)	325 (67.8)	479
Total	171	529	700	158	362	520

from the disease process or as a direct complication of the procedure.[2] Furthermore, this procedure fails in 20% of cases and those failed cases have a mortality of 40%. Vigorous clinical assessment is therefore necessary before a patient is classified as being at high risk. Inadequate optimisation of supportive treatment often leads to signs such as hypotension and sinus tachycardia, which in turn predispose to further chest pain, interpreted as postinfarction angina even in the absence of electrocardiographic changes. Chest crepitations related to aging are often confused with those associated with pulmonary oedema. One prime example is inferior myocardial infarction with right ventricular extension. This is due to an occlusion of a dominant right coronary artery, which carries a relatively good prognosis. Suboptimal fluid replacement and the indiscriminate use of inotropic agents without prior careful assessment of left ventricular function with echocardiography and guidance by Swan-Ganz catheterisation lead to patients being classified as at high risk without having prior or incidental left coronary artery disease.

The fact that rescue angioplasty for right coronary artery occlusion is associated with excessive complications[3] should lead doctors to question whether this form of intervention is putting a patient's life at risk, turning a relatively benign course into a fatal one.

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1 Beller GA. Determining prognosis after acute myocardial infarction in the thrombolytic era. *BMJ* 1997;315:761-2. (27 September.)
2 Ellis SG, Van de Werf F, Ribeiro-daSilva E, Topol EJ. Present status of rescue coronary angioplasty: current polarisation of opinion and randomised trials. *JACC* 1992;19:681-6.
3 De Franco AC, Ellis SG. Rescue angioplasty. In: Sigwart U, Bertrand M, Serruy PW, eds. *Handbook of cardiovascular intervention.* Edinburgh: Churchill Livingstone, 1996:431-48.

Author's reply

EDITOR—Lim and Shiels make a valid point regarding the increased risk of rescue angioplasty after presumed failed thrombolysis, but I never addressed the issue of early angioplasty in my editorial. The thrust of my discussion regarding risk stratification related to the identification of clinical variables and variables determined with non-invasive tests that could be used to select those patients after infarction who are most likely to benefit from coronary angiography and coronary revascularisation.

With respect to clinical variables, I mentioned that the combination of rales in over a third of the lung field, hypotension, and sinus tachycardia on admission was an important observation that indicated a high risk status, since these haemodynamic alterations reflect a large area of myocardium at jeopardy with ischaemia or necrosis, or both; they can also point to underlying multivessel disease or a large infarct, or both. I agree that each one of these haemodynamic changes in isolation is not highly specific for a high risk designation. Certainly, crackles at the lung bases alone without evidence of other signs of left ventricular pump failure can indicate atelectasis or pulmonary disease. Hypotension in isolation, without sinus tachycardia and pulmonary rales, can be due to volume depletion or right ventricular infarction and not be secondary to extensive left ventricular dysfunction.

The main message of my editorial was that a routine invasive strategy for risk assessment before discharge is not superior to a watchful waiting, non-invasive strategy in which patients undergo angiography for high risk clinical findings or for spontaneous or inducible ischaemia within or remote from the infarct zone. Recent data reported from the VA non-Q wave infarction strategies in-hospital trial, in which 920 patients with non-Q wave infarction were randomised to an initial invasive strategy or an initial conservative strategy, support this approach.[1] At one year after discharge there was no difference in cardiac death or recurrent infarction between the two groups. Also, new data from Yusuf et al showed no difference in outcome for patients with infarction admitted to hospitals with cardiac catheterisation facilities (catheterisation rate 66%) compared with those admitted to hospitals with no catheterisation facilities on site (catheterisation rate 34%).[2]

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1 Boden WE, O'Rourke RA, Dai H, Crawford MH, Blaustein AS, Deedwania PC, et al. Improved clinical outcomes in non-Q-wave infarction patients randomized to a conservative "ischemia-guided" strategy compared to an invasive/interventional strategy: results of the multicenter VA non-Q-wave infarction strategies in-hospital (VANQWISH) trial [abstract]. *Circulation* 1997;96(suppl I):207.
2 Yusuf S, Flather MD, Pogue JM, Hunt D, Varigos J, Piegas LS, et al. Factors affecting the use of invasive facilities in patients with unstable angina or suspected non-Q wave infarction [abstract]. *Circulation* 1997;96(suppl I):535-6.

Number of unexplained symptoms and diseases is decreasing

EDITOR—In his editorial Mayou explains that the management of patients with medically unexplained physical symptoms is too often inappropriate, even though effective interventions are available.[1] He essentially attributes this to the persistence of the idea of "mind-body dualism" in the medical profession, which neglects important interactions between physiological, psychological, and social factors.

I agree with what he says about this socially and economically important subject, but I would emphasise another factor: our scientific ignorance and frequent arrogance. Too easily and too frequently we attribute to mental illness symptoms that turn out to be those of well defined organic diseases (which does not exclude the role of superimposed social or psychological factors). Mayou says "there is scant provision ... for the patient with somatic complaints who has neither physical disease nor severe mental illness." This sentence reminds us that these patients tend to be forgotten, but "recognised" or "known" should probably have preceded the term "physical disease."

Patients with muscular symptoms are a good example of this. Many, classified years ago as mentally ill, later turned out to have well defined disease. A typical example is patients with McArdle's disease, who suffer from chronic muscle fatigue with exercise. Many—at least, the older ones—were initially classified as having purely psychological or psychiatric disease; they were consequently regarded as being lazy and dealt with as such, typically when they were conscripted into the army. Even worse, they were usually forced to exercise, which has since been shown to be potentially dangerous since it can lead to muscle damage and renal failure. They are now known to have a genetically determined lack of a muscle enzyme essential for glycogen breakdown and use for energy production (muscle phosphorylase deficiency).

These errors of classification have moral, psychological, and economic implications for patients, their families, and society. Some doctors still seem to be unaware of their own ignorance. We should be modest and cautious, perhaps stating that our conclusions are "to the best of our knowledge" and may not be correct. Even though the list of unexplained diseases and symptoms is slowly decreasing through scientific progress, it is unlikely ever to disappear totally.

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1 Mayou R. Treating medically unexplained physical symptoms. *BMJ* 1997;315:561-2. (6 September.)

The caring doctor is an oxymoron

General practice will develop best if "caring" is replaced by professionalism

EDITOR—Mackenzie's hypothesis that the term "the caring doctor" is an oxymoron struck a chord with many doctors I speak to.[1] I have long thought that general practice will develop best if we replace the sham of caring with better professionalism. This does not stop us practising good medicine in a compassionate and considerate manner. We spend a lot of time teaching consulting skills to registrars. Good consulting is not the same as "niceness," and the term "the caring professions" is patronising and arrogant.

There is still a place for the registered list of patients, but in a computerised world it is a tool for targeting and delivering good medicine—for example, in secondary prevention. The modern world is demanding of us. If general practice is to remain vibrant and attract high quality recruits we have to develop practice beyond the personal attributes of individual doctors. We need to think imaginatively, to continue the drive for better organisation, to use information technology to the full, to recognise the strengths of other members of the team, to delegate

and give up some of our traditional perceived duties to those who often do them better. Surely routine visiting is a thing of the past.

Practitioners as team leaders need to have the time and energy to step back and look critically at what the practice does as a whole and not to be afraid to initiate change. Too much of what we do still depends on tradition rather than planning. This opens the doors to external influences, as we have seen in the past few years to our disadvantage.

Clinical audit should no longer be a threat to most of us, and perhaps we need to open the debate about clinical outcomes in practice. This debate should include the limitations that patients should expect of our services, and their responsibilities towards their own health. It should be aimed at reducing the dependency on doctors that seems to be ingrained in some quarters—for example, for numerous prescriptions for minor illness.

I suspect that patients in general would support attempts to improve services at the expense of personal doctoring, which is probably more important to some doctors than to most patients. Inevitably this may touch on the question of standards, but if the debate is open and the standards explicit then most of us have nothing to fear.

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1 Mackenzie GM. The caring doctor is an oxymoron. *BMJ* 1997;315:687-8. (13 September.)

Frequent callers to cooperatives provoke same feelings there

EDITOR—I strongly disagree with Mackenzie's contention that patients receive better care from doctors who work in a cooperative than from their own general practitioner.[1] In my experience, doctors who work in a cooperative provide safety-first, firefighting medicine to deal with acute problems. The decision rests between admitting the patient to hospital or managing him or her at home until the next day. The lack of notes and an accurate, reliable medical history is certainly not a bonus and can be a major hindrance. Most cooperatives rapidly get to know their frequent callers, who provoke the same feelings out of hours as they do in their own practice.

Familiarity can breed contempt, but being aware of this risk can prevent missed diagnoses. Familiarity can also provide huge benefits for somatisers in rescuing them from repeated investigations by doctors unfamiliar with their history. If all patients were seen by doctors working in cooperatives, fat files would be even fatter and surgeries would resemble hospital outpatient clinics, where patients see a different senior house officer at every visit.

To me the oxymoron is "depersonalised general practice." Let's improve our consultation skills and not lose the benefits of long term continuity of care.

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1 Mackenzie G. The caring doctor is an oxymoron. *BMJ* 1997;315:687-8. (13 September.)

GPs will soon become extinct

EDITOR—Mackenzie's personal view was undoubtedly intended to be provocative.[1] I was provoked, not only to consult my dictionary on that curious word "oxymoron" but also to challenge Mackenzie's profoundly negative view of personal care in general practice.

There is a growing danger that the best feature of Britain's NHS (the family doctor who visits patients in their homes) will soon become extinct, driven to the wall by the primary care physician with his or her burgeoning team and an efficient computer system. What is wrong with being both clinically and administratively efficient and preserving that special bond between ill people and the doctor who knows them best?

Bring back the individual commitment, the romance, and the poetry into general practice.

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1 Mackenzie GM. The caring doctor is an oxymoron. *BMJ* 1997;315:687-8. (13 September.)

Out of hours emergencies and continuing problems need different approaches

EDITOR—Mackenzie's argument in his article entitled "The caring doctor is an oxymoron" is based on the central assumption that, with improving records and information technology, most doctors should have enough information to negate the usefulness of patients seeing doctors who think that they know the patients well.[1] I disagree.

It is my experience that in general practice, as in the whole of medicine, the state of medical records and information technology is still far removed from such an ideal. Consultation records are often partial, illegible, or completely absent. Current and past problem summaries are frequently incomplete, and attempting to obtain the information from the patient is time consuming and often fruitless. Therefore continuity of care in general practice continues to be valuable because the familiar doctor's memory can compensate for many of these deficiencies.

Mackenzie does not mention the time that new doctors take to read even the most perfect of medical records to update themselves fully on a patient's progress to date. This eats into valuable consultation time. If the patient sees a familiar doctor then this time is saved.

Finally, I take issue with Mackenzie's argument about the superiority of care provided by doctors working in cooperatives over that provided by the patient's own general practitioner. Even if this were true in general (which I doubt) it is only partially relevant as it relates to out of hours emergency consultations. By their nature, out of hours emergencies are amenable to care by any general practitioner with only an outline of the patient's medical history. The more complex continuing problems, with their mixture of physical, psychological, and social aspects, which are the meat of general practice during working hours, require a different approach.

I believe that continuity is essential for efficient care—quite apart from any sentimental attachment to the idea of the "cradle to grave" doctor.

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1 Mackenzie GM. The caring doctor is an oxymoron. *BMJ* 1997;315:687-8. (13 September.)

GPs could refer patients to clinical hypnotherapists

EDITOR—Mackenzie believes that the term "a caring doctor" is an oxymoron, maintaining that, at least in general practice, "overpersonalising care can result in poor delivery of appropriate medicine."[1] I believe that by removing the personal touch he is missing out on a valuable, but time consuming, therapeutic tool. He dislikes the "caring doctor" approach because of its effect on general practitioners' morale, saying that what wears general practitioners down is the "constant assault from the same people, which dulls the intellect and forces general practitioners to operate in a completely different way from how their training taught them."

Of course, being nice takes time—a precious commodity. Being nice, however, is a valuable therapeutic tool in itself whose value is often overlooked. Doctors who believe that their abilities should be assessed solely on their performance as clinicians are not necessarily providing all the help that some of their patients need.

Mackenzie's underlying implication is that good clinicians do not expect to see their patients either for very long or for many repeat visits. So what does that make doctors who cannot seem to get rid of some patients? Are they bad clinicians? Of course not. The patients are benefiting in some way from the visit itself, otherwise they wouldn't come. But the benefit does not come out of a bottle, cannot easily be quantified, and does not show up in an audit in a positive way.

Once a general practitioner has tried all the medical options, perhaps another form of help is more appropriate for those patients who will not go away. Patients now recognise that doctors do not have all the answers, and it has become acceptable for doctors to receive help themselves. If doctors feel uncomfortable being nice and spending extra time with particular patients then they can now refer them to another source of help, a clinical hypnotherapist: one who has the time to be nice to patients and has been professionally trained to encourage them to take responsibility for themselves and deal with their own problems. This will certainly unclog the surgery systems, freeing the doctors to see those patients they can help most effectively, reducing their stress, improving their morale, and, dare I say it, even helping the patient too.

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1 Mackenzie GM. The caring doctor is an oxymoron. *BMJ* 1997;315:687-8. (13 September.)